# NEW SETTLED BENEFIT SUMMARY
# JULY 1, 2020

| BENEFIT | CITY OF WORCESTER DIRECT | CITY OF WORCESTER ADVANTAGE | BCBS NETWORK BLUE NEW ENGLAND | BCBS BLUE CARE ELECT PREFERRED (Those Residing out of New England only) | |
|---|---|---|---|---|---|
| | | | | In Network | Out of Network |
| Deductible | $400 Ind/$800 Fam | $500 Ind/$1,000 Fam | $500 Ind/$1,000 Fam | $500 Ind/$1,000 Fam | |
| Out of Pocket Maximum | $5,000 Ind/$10,000 Fam – Med<br>$2,000 Ind/$4,000 Fam – Rx | $5,000 Ind/$10,000 Fam – Med<br>$2,000 Ind/$4,000 Fam – Rx | $5,000 Ind/$10,000 Fam – Med<br>$2,000 Ind/$4,000 Fam – Rx | $5,000 Ind/$10,000 Fam – Med<br>$2,000 Ind/$4,000 Fam – Rx | |
| Wellness Visit | $0 | $0 | $0 | $0 | 20% co-insurance<br>(after deductible) |
| PCP Office Visit | $20 | T1: $20 \| T2/T3: $25 | T1: $20 \| T2: $30 \| T3: $40 | $40 | 20 % co-insurance<br>(after deductible) |
| Specialist Visit | $35 | T1: $40 \| T2/T3: $50 | $50 | $50 | 20% co-insurance<br>(after deductible) |
| Prescriptions | Retail = $10/$30/$60<br>30-Day Supply<br>**Mail-away =$25/$75/$180<br>90-Day Supply | Retail = $10/$30/$60<br>30-Day Supply<br>**Mail-away =$25/$75/$180<br>90-Day Supply | Retail = $10/$30/$60<br>30-Day Supply<br>**Mail-away =$25/$75/$180<br>90-Day Supply | Retail = $10/$30/$60<br>30-Day Supply<br>**Mail-away =$25/$75/$180<br>90-Day Supply | |
| Inpatient Hospital | $275<br>(after deductible) | T1: $275 \| T2: $500 \| T3: $750<br>(after deductible) | T1: $275 \| T2: $750 ($800 Select, no deductible) \| T3: $1,000<br>(after deductible) | 10% co-insurance<br>(after deductible) | 30% co-insurance<br>(after deductible) |
| Outpatient Surgery | $250<br>(after deductible) | T1: $250 \| T2: $350 \| T3: $500<br>(after deductible) | Surgical day care facility – T1: $250 \| T2: $500 ($550 Select, no deductible) \| T3: $750<br>Ambulatory surgical facility - $250<br>(after deductible) | Office setting $50<br>Ambulatory surgical facility $500 per admits<br>(after deductible) | 20% co-insurance<br>(after deductible) |
| Diagnostic Services<br>Lab, X-ray, etc. | Covered in full<br>(after deductible) | Covered in full<br>(after deductible) | Covered in full<br>(after deductible) | 10% co-insurance<br>(after deductible) | 30% co-insurance<br>(after deductible) |
| CT scans, MRIs, PET scans | $50 (non-hospital setting) or $100 (hospital setting) for MRIs, PET, and CT scans<br>(after deductible) | $50 (non-hospital setting) or $100 (hospital setting) for MRIs, PET, and CT scans<br>(after deductible) | T1: $100 \| T2: $250 \| T3: $500<br>(after deductible) | 10% co-insurance<br>(after deductible) | 30% co-insurance<br>(after deductible) |
| Short-term Rehab:<br>Outpatient, OT, PT | $20 co-pay<br>60 visits per plan year<br>(after deductible) | $25 co-pay<br>60 visits per plan year<br>(after deductible) | $50 co-pay<br>60 visits per CY | $50 co-pay<br>100 visits per CY<br>no deductible | 20% co-insurance<br>100 visits per CY<br>(after deductible) |
| Skilled Nursing | Covered in full<br>Up to 100 days per plan year<br>(after deductible) | Covered in full<br>Up to 100 days per plan year<br>(after deductible) | Covered in full<br>Up to 100 days per CY | 10% co-insurance<br>Up to 100 days per CY<br>(after deductible) | 30% co-insurance<br>Up to 100 days per CY<br>(after deductible) |
| Chiropractor | $20 co-pay<br>12 visits per plan year | $25 co-pay<br>12 visits per plan year | $50 co-pay | $50 co-pay | 20% co-insurance<br>(after deductible) |
| Outpatient Mental Health | $20 co-pay | $25 co-pay | $20 co-pay | $40 co-pay | 20% co-insurance<br>(after deductible) |
| Durable Medical Equipment<br>(wheelchairs, crutches, etc.) | 20% co-insurance<br>(after deductible) | 20% co-insurance<br>(after deductible) | 20% co-insurance | 20% co-insurance | 40% co-insurance<br>(after deductible) |
| ER Visit (Waived if Admitted) | $150 | $150 | $150 | $150 | $150 |
| Ambulance | Covered in full if medically necessary or when ordered by a physician<br>(after deductible) | Covered in full if medically necessary or when ordered by a physician<br>(after deductible) | Covered in full if medically necessary or when ordered by a physician<br>no deductible | Emergency: 10% co-insurance - no deductible.<br>Medically necessary: 10% co-insurance<br>(after deductible) | Emergency:10% co-insurance - no deductible<br>Medically necessary: 30% co-insurance<br>(after deductible) |
| **PREMIUM RATES**<br>Monthly (IND/FAM) | $613.85 / $1,542.05 | $758.10 / $1,882.21 | $901.67 / $2,331.13 | $1,017.73 / $2,631.50 | |
| **Employee Cost**<br>Weekly (IND/FAM)<br>Monthly (IND/FAM) | $35.41/ $88.96<br>$153.46 / $385.51 | $43.74 / $108.59<br>$189.53 / $470.55 | $52.02 / $134.49<br>$225.42 / $582.78 | $58.72 / $151.82<br>$254.43 / $657.88 | |

*This is a brief summary of some of the benefits offered. Additional details can be found in the complete plan descriptions.
**Mandatory mail-away for maintenance drugs, or 90-day at retail for maintenance drugs; however, only allowed at CVS pharmacies.